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Implementing psychological therapies for people with psychosis in South East London and England.

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Abstract (141 words)

International treatment guidelines have recommended psychological therapies for people with psychosis for nearly two decades. Despite evidence of clinical and cost effectiveness, and positive feedback from service users and caregivers, implementation remains problematic. This article reports on work in South East London to improve access and effective delivery, and two recent initiatives in the National Health Service in England. The focus is on operationalising key facilitators: i) adequate training, time for delivery, and supervision for staff; ii) systems to identify the target caseload and monitor access, provision, and outcomes; iii) effective pathways for offering and delivering therapy; and iv) organisational support. Targeting these facilitators should improve implementation in any context. New investment, when these facilitators are in place, can be readily translated into effective delivery, but delivery at scale may still require alternative models. Lessons learned and future directions are discussed.

Introduction

Psychosis is a serious mental health condition, characterised by positive (hallucinations, delusions), negative (apathy, withdrawal), disorganised, and affective symptoms (1). The global personal (physical morbidity, early death, poor quality of life) and societal (cost of formal and informal care, lost productivity) disease burden of schizophrenia-spectrum psychosis is high (2). Since the late 1990s, international guidelines for the treatment of schizophrenia and psychosis have consistently recommended offering cognitive behavioural interventions, individually (cognitive behavioural therapy for psychosis, CBTp), and/or with family members when there is close contact (family interventions in psychosis, FIp) (1). Interventions draw on evidence-based cognitive models of psychosis and caregiving, and aim to change appraisals of and responses to distressing or problematic experiences, to improve wellbeing and functioning (3). Meta-analytic evidence suggests small but consistent improvements and, through reductions in the use of inpatient beds and crisis services, the potential for cost-effective delivery (1,2). However, despite the severity of the condition, evidence for the clinical and cost-effectiveness of recommended interventions, and demand from service users and families, compliance with guidelines is poor: in United Kingdom (UK) mental health services, delivery is below 10% for CBTp and lower for FIp (2). Strategies to improve implementation, therefore, are a focus of interest, and the literature identifies four key aspects: i) adequate training, time for delivery, and supervision for staff; ii) systems to identify the target caseload and monitor access, provision, and outcomes; iii) effective pathways for offering and delivering therapy; and iv) organisational support (4). This article reports on implementation and training work in the South London & Maudsley National Health Service (NHS) Foundation Trust (SLaM) and at King's College, London (KCL) in the UK, and local experiences of two recent national implementation programmes. Successful strategies, limitations, implications, applicability to other settings, and areas for future development are highlighted.

Local implementation

Our local implementation work aimed to improve routine care to meet the psychological therapy recommendations of the UK National Institute for Health and Care Excellence (NICE) Schizophrenia guidance, to offer CBTp to everybody with psychosis, and FIp to everybody with psychosis in close

contact with a family member (1,5). We offered workshops and supervision to psychological therapists to engage our community and inpatient mental health teams, which led to the development of specialised training (see *CBTp Training* section below). We supported services to produce case registers of people with schizophrenia-spectrum psychosis, their contact with caregivers, provision of recommended psychological therapies, and pre-post therapy outcomes. We found that offers of therapy, given the difficulties engaging people with psychosis, were best made by a therapist who could 'match' their approach to the person's presentation, accommodating, for example, high conviction in an external source of the difficulties. For the wider workforce, offers were better limited to agreement to an initial conversation with a therapist colleague (5). Organisationally, each team identified a 'champion' who joined an implementation steering group, to guide the work, and senior managers were asked to report on delivery as part of their performance management. Over time, information technology resource was committed to automating delivery and outcomes reporting, using computerised patient records. Our delivery rates have steadily improved, and, through recent investment in specialist therapy posts in dedicated psychosis care pathways, have reached three times the national average, with pre-post outcomes of medium effect size. Challenges include identifying the target caseload in the context of heterogeneous presentations and diagnostic uncertainty, and ensuring representative completion of paired outcomes. Rating every session, and using graduate psychologist assessors, rather than relying on therapists who may prioritise other therapy demands over outcome collection, improves paired outcome completion (8,9).

CBTp training

To better train the therapy workforce, we developed a two-year postgraduate CBTp programme at KCL (6), which has now run for 15 years. The programme emphasises supervised practice: students work with at least four cases, closely supervised using audio recordings. To ensure that supervision is of a sufficiently high standard, programme supervisors need to have had service delivery and management experience and close, expert supervision of their own therapy skills, through research, training, or practice in a centre of excellence. We have published preliminary evidence of positive patient outcomes during training (7). We train students to work effectively as part of the wider

management of the condition in their service context, and to actively identify and engage the target population, as referral flow is often an issue (5).

Implementation has been best for those with postgraduate academic qualifications, who have at least half of their working hours dedicated to therapy delivery, and protected from competing service demands, during and after training (6). Successful implementation has necessitated robust liaison between academic and clinical organisations, with the university accommodating variability in programme size and expected income according to workforce demand and funding, as well as flexibility in completion as students train whilst working full-time, with complex, high-risk caseloads. Training supports graduates to arrange ongoing local supervision; to establish systems for managing and monitoring offers, delivery and outcomes; and to act as champions for therapy delivery in changing service contexts. We have offered free 'top-up' supervision groups for staff who have completed our training and do not have specialist supervision in place, to support their implementation.

Implementation in practice: the South East London Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI) psychosis demonstration site

During 2012, the UK government launched plans to extend their Improving Access to Psychological Therapies (IAPT) programme for people with anxiety and depression to people with psychosis, bipolar affective disorder and personality disorders. Potential demonstration sites were invited to compete for funding. Selection was based on organisational readiness (i.e. established systems for identifying cases, monitoring offers, delivery and outcomes, and training and supervising staff), to rapidly translate new funding into therapy delivery, and show how this could be achieved. Our local services in SLaM hosted one of the two selected psychosis sites (8). We used the funding to appoint therapists who had been trained to competence, assessed using standardised measures (6), or who were willing to complete training. We aligned the new provision closely with routine secondary care to ensure a steady flow of suitable referrals, but operated alongside rather than wholly within the team, to prevent therapists being overwhelmed by other service demands, such as managing crises and risks. The sites ran for three years, with 6-24 month follow-ups completed during 2016. The main psychological wellbeing outcome measure was completed every session, acceptability was good, and

rates of paired completion were high (97%). Graduate assessors completed longer pre-, mid-, and post-therapy assessments. We were funded to increase referrals by 50% from n=100/annum: we accepted n=300 over the first 14 operational months with equity across gender, age, and ethnicity (8). We also demonstrated medium to large pre-post improvements in wellbeing, psychotic symptoms, and functioning, and potential cost savings through reduced psychiatric hospital inpatient admissions and crisis service use (8). Independent, user-led, evaluation showed high satisfaction, and service user and carer involvement was a feature of the initiative (http://mcpin.org/a-service-user-evaluation-of-iapt-for-people-with-a-severe-mental-illness-2/; https://vimeo.com/user2051960/review/142126508/ 56e6bcfd3f).

As part of the IAPT-SMI programme, expert panels were convened to develop consensus practitioner and supervisor competence frameworks for CBTp and FIp, and associated training curricula (http://www.ucl.ac.uk/clinical-psychology/CORE/competence_mentalillness_psychosisandbipolar.html). In addition to specific therapy competences, the frameworks include knowledge about the condition, assessing and treating common comorbidities, and managing the wider care context. Supervisor competences require expertise in the interventions as well as governance; we have found that supervisor training applicants to KCL often need to undertake a year of supervised practice to acquire therapist competences alongside extending their supervisory repertoire and expertise.

Building on IAPT-SMI: the UK Early Intervention Psychosis Access and Waiting Time Standard

From 2015-20, further government funding has been allocated to improve access to NICE concordant care, including CBTp and FIp, starting with Early Intervention Psychosis (EIP) services. EIP usually provides 2-3 years of multidisciplinary care for first presentations of a range of psychotic conditions. There are plans to extend the access initiative over time to services for established (second or further episode) psychosis. During 2015-16, funded training places were awarded by competitive tender to universities and other training providers, based on their ability to train newly appointed and existing EIP therapists to the specifications of the IAPT-SMI CBTp and FIp competence frameworks. FIp training was delivered early in 2016, most commonly as a five-day course in behavioural communication skills; locally we also offered a one-year training in cognitive behavioural family

intervention, including supervised practice, with good impact on delivery. For CBTp, brief supervisor training began early in 2016, and therapist training from September 2016. Courses have offered 'top-up' specialist training for those with pre-existing competences in CBT for emotional disorders, and two-year programmes, starting with CBT for emotional disorders and progressing to CBTp. There are now nine NHS-commissioned specialist CBTp courses in centres of excellence in England, most newly established as a result of increased commissioning. In terms of the success of the initiative, delivery rates have improved, but work is ongoing to improve data quality, and to safeguard allocated funds in the face of other financial pressures.

Lessons learned, policy implications and future directions

Our implementation efforts over time show how targeting resources can improve delivery and build systems for implementation. Effective specialist training and supervision, and facilitating access routes for the target caseload, are the cornerstones of improved delivery. Developing training pragmatically, through research, clinical, and professional training centres of excellence, where there is a critical mass of expert practitioners, has sidestepped the difficulties of effecting widescale change in trainers' knowledge and attitudes, and established professional training and practice, identified as key impediments to national implementation in the United States (9). Trained practitioners can develop systems for monitoring access, delivery and outcomes, building relationships with wider services and promoting organisational support using strategies tailored to their specific local and national contexts, accommodating, e.g. different psychosis prevalence rates and service/funding models.

Nevertheless, even following substantial, successful implementation work, UK delivery rates continue to fall short of NICE recommendations. Notwithstanding evidence of cost savings through reduced inpatient and crisis service use, sustained investment has been required to increase delivery, and no service model as yet has increased access to CBTp or FIp by improving existing services without *any* additional investment (e.g. for training places). Step changes to services may therefore be required to fully meet guidance with limited investment, such as the development and adaptation of 'low-intensity', brief, or protocol-based interventions, that could potentially be delivered by a wider workforce, alongside standard, individualised CBTp and FIp (10). Research and funding policy now

should focus not only on the continued development and refinement of therapies to achieve greater effects more consistently, but also on the most efficient models of therapy training and delivery, across service contexts and the wider population of those to be treated, in order to achieve the recommendations of universal access.

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